Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration

Speech/Audiology Program

Billing Instructions
for
Audiologists and Speech-Language Pathologists

(WAC 388-545-0700)

Copyright Disclosure

About this publication

This publication supersedes all previous billing instructions for Speech Therapy Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School Medical Services
- Neurodevelopmental Centers
- Outpatient Hospital

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

How do I apply for a provider number?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	**360.664.0300**
I-O	**360.753.4712**
P-Z	**360.753.4711**

Where do I send hardcopy claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How do I request billing instructions?

Check out our website:

http://maa.dshs.wa.gov

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
800.562.3022

Who do I call if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
800.562.-3022

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
800.562.6136

Electronic billing?

http://maa.dshs.wa.gov/ecs

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Client - An applicant for, or recipient of, DSHS medical care programs.

Department - The state Department of Social and Health Services (DSHS). (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Health and Recovery Services Administration (HRSA) - An administration within the Department of Social and Health Services (DSHS) responsible for disability determinations, medical care, mental health services, and alcohol/substance abuse prevention and treatment for low-income residents in Washington State.

Health Care Financing Administration Claim Form (HCFA-1500) - A claim form used to bill for Medicaid services.

Health Maintenance Organization (HMO) – An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis. (WAC 388-500-0005)

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care. (WAC 388-538-001)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to person's eligible for the:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS use to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, `course of treatment' may include mere observation or, where appropriate, no treatment at all. (WAC 288-500-0005)

Primary Care Case Manager (PCCM) – A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Program Support, Division of (DPS) - The division within the Health and Recovery Services Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

Provider, or Provider of Service - An institution, agency, or person:

(a) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and

(b) Eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number - A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with the Health and Recovery Services Administration.

Remittance and Status Report - A report produced by the claims processing system in the HRSA Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Client Eligibility

Who is eligible? [WAC 388-545-0700 (2)]

Clients presenting MAID cards with the following identifiers are eligible for services under the Speech/Audiology Program:

- **CNP** (Categorically Needy Program)
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)
  - ✓ Only clients 20 years of age or younger; or
  - ✓ Clients receiving home health care services only

Who is not eligible?

Clients presenting MAID cards with the following identifiers are not eligible for services under the Speech/Audiology Program:

- **Family Planning Only** (Limited Coverage)
- **QMB Medicare Only**

Are clients enrolled in managed care eligible?

YES! Clients with an identifier in the HMO column on their MAID card are enrolled in one of HRSA's Healthy Options managed care plans and must receive all speech/audiology services directly through their Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their MAID card.

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Coverage

HRSA pays only for covered speech/audiology services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- For conditions which are the result of medically recognized diseases and defects;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What is covered? [WAC 388-545-0700 (3)]

Unlimited speech/audiology visits for clients 20 years of age and younger.

HRSA covers the following services per client, per calendar year:

- One (1) medical diagnostic evaluation;
- A second medical diagnostic evaluation at the time of discharge for the following HCPCS diagnoses codes:

HCPCS Diagnosis Code	Description
348.1	Anoxic brain damage
436	Acute, ill-defined, cerebrovascular disease
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
854, 854.1	Intracranial injury of other and unspecified nature;

- Twelve (12) speech/audiology program visits; and
- Twenty-four (24) additional speech/audiology program visits (see next page).

Additional Coverage (Client 21 years of age and older)

[WAC 388-545-0700 (4)(e)]

HRSA will cover a maximum of 24 speech/audiology program visits in addition to the original 12 visits only when billed with one of the following **principle** HCPCS diagnosis codes.

HCPCS Diagnosis Codes	Condition
237.7-237.72	Neurofibromatosis
315.3-315.39, 315.5-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
315.4,	Severe oral/motor dyspraxia
335.20	Amyotrophic lateral sclerosis (ALS)
340	Multiple sclerosis
343-343.9	Cerebral palsy (CP)
344.0	Quadriplegia
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
436	Acute, but ill-defined, cerebrovascular disease
741.9	Meningomyelocele
749-749.25	Cleft palate and cleft lip
758.0	Down's syndrome
781.3	Lack of coordination
784.3	Severe aphasia
784.5	Other speech disturbance (severe Dysarthria)
787.2	Severe dysphagia
800-800.9	Fracture of vault of skull
801-801.9	Fracture of base of skull
803-803.9	Other and unqualified skull fractures
804-804.9	Multiple fractures involving skull or face with other bones
806.0-806.19	Fracture of cervical column, closed or open
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
851.1-851.9	Cerebral laceration and contusion
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
853-853.1	Other and unspecified intracranial hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature
900-900.9	Injury to blood vessels of head and neck
941.33,941.35,941.38, 941.43,941.45,941.48, 941.53,941.55,941.58	Severe burn of face, head, and neck
946.3-946.5	Burns of multiple specified sites
947.0-947.2	Burn of internal organs
952.0-952.09	Spinal cord injury without evidence of spinal bone injury-cervical

Are school medical services covered?

HRSA covers speech/audiology services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to HRSA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-0700 (6)]

HRSA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

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Speech-Language Pathology

For HRSA to pay for speech-language therapy, a client must have a medically recognized disease or defect which requires speech-language therapy services.

Who is eligible to provide speech-language therapy?
[WAC 388-545-0700 (1)(a)(b)]

Speech-language therapy must be provided by a speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Language, and Hearing Association or by an individual who has completed the equivalent educational and work experience necessary for such a certificate.

Swallowing Evaluations

Swallowing (dysphagia) evaluations must be performed by a speech-language pathologist who:

- Holds a master's degree in speech-language pathology; and
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques; and
- (May include) A videofluoroscopy for further evaluation of swallowing status and aspiration risks.

Visit Limitations

NOTE: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

If time is included in the CPT procedure code description, the beginning and end times of each therapy modality must be documented in the client's medical record

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other speech-language allowed CPT procedure codes.

- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.

- HRSA allows evaluation of speech (CPT procedure code 92506) once per year, per client, per provider and it is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.19	Intracranial injury of other and unspecified nature

- Duplicative services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request HRSA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

HRSA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

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Audiology

HRSA may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects.

Who is eligible to provide audiology services?
[WAC 388-545-0700 (1)(c)]

Audiologists who are appropriately licensed or registered to provide speech/audiology services within their state of residence to HRSA clients.

What type of equipment must be used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

What about children with special health care needs?

Refer to HRSA's Hearing Aid Program Billing Instructions for information regarding Children with Special Health Care Needs (CSHCN). (See *Important Contacts*.)

Visit Limitations

NOTE: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other audiology allowed CPT procedure codes.

- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.

- Evaluation of speech (CPT procedure Code 92506) is allowed once per year, per client, per provider and is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature

- For caloric vestibular testing (CPT procedure code 92543), bill one unit per irrigation. If necessary, you may bill up to four units for each ear.

- For sinusoidal vertical axis rotational testing (CPT procedure code 92546), bill 1 unit per velocity/per direction. If necessary, you may bill up to 3 units for each direction.

How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request HRSA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

Division of Medical Management
Medical Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

The Speech & Audiology Fee Schedule (previously found on pages 13-16) is now located in the appendix. To view or download the Fee Schedule, click Appendix.

HRSA's Fee Schedules

You may access HRSA's fee schedules at: http://maa.dshs.wa.gov. Click on "Billing Instructions/Numbered Memoranda" and accept the AMA copyright agreement. Then click on "Fee Schedules." For subsequent visits, you may access the fee schedules at: http://maa.dshs.wa.gov/RBRVS/RBRVS%20Fee%20Schedule%20File%20Downloads.htm

Billing

What is the time limit for billing?

State law requires that you present your final bill to HRSA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill HRSA within 365 days after you provide a service(s).

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill HRSA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **HRSA will not pay if:**

  - ✓ The service or product is not covered by HRSA;
  - ✓ The service or product is not medically necessary;
  - ✓ The client has third party coverage, and the third party pays as much as, or more than HRSA allows for the service or product; or
  - ✓ HRSA is not billed within the time limit indicated above.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

[1] **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill HRSA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's medical assistance IDentification (MAID) card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for clients who are eligible for both Medicare and Medicaid?

Some Medicaid clients are also eligible for Medicare benefits. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payer of claims.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. HRSA will pay up to Medicare's Allowable or HRSA's allowable, whichever is less.

An **X** in the *Medicare* area on the client's MAID card (area 9) indicates Medicare enrollment.

QMB (Qualified Medicare Beneficiaries Program Limitations):

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

- If the client has a CNP or MNP MAID card in addition to the QMB MAID card, and the service you provide is covered by Medicare *and* Medicaid, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- HRSA will also reimburse for services that are *not* covered by Medicare but *are* covered under the CNP or MNP program.

QMB-MEDICARE Only (Qualified Medicare Beneficiaries)

The reimbursement criteria for this program is as follows:

- If Medicare **and** Medicaid cover the service, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- If only Medicare and **not** Medicaid covers the service, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- If Medicare does not cover or denies the service, HRSA will **not** reimburse for it.

What records does HRSA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Health and Recovery Services Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and shall include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Health and Recovery Services Administration (HRSA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: Required. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, HRSA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill HRSA, the claim will be denied.

19. **Reserved for Local Use**: Enter "T" for school contracted services that are noted in the client's IEP or IFSP.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 1999 = 070499). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate codes for this program:

Code Number	To Be Used For
22	Outpatient
11	Office
12	Home
99	Other

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

Group: Enter the group number assigned by HRSA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

Sample HCFA-1500 Claim Form

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Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the HCFA-1500 claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to HRSA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to HRSA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the HRSA Remittance and Status Report within 30 days of the Medicare statement date, you should bill HRSA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill HRSA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to HRSA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

Refer to HRSA's current *General Information Booklet* for instructions on completing the HCFA-1500 claim form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following HCFA-1500 instructions relate to Medicare Part B/Medicaid Crossovers, see link above for general HCFA-1500 instructions.

Note: The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

Field No.	Name	Field Required	Entry
19.	**Reserved For Local Use**	Yes	When Medicare allows services, enter *XO* to indicate this is a crossover claim.
22.	**Medicaid Resubmission**		When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).
24B.	**Place of Service**	Yes	These are the only appropriate codes for this program: **Code Number** — **To Be Used For** 22 — Outpatient 11 — Office 12 — Home 99 — Other
24C.	**Type of Service**	Yes	Enter a **3**.

Field No.	Name	Field Required	Entry
24D.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed. **Coinsurance and Deductible**: Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.
24K.	**Reserved for Local Use**	Yes	Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).
27.	**Accept Assignment**	Yes	Check **yes**.
29.	**Amount Paid**	Yes	Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here**.
30.	**Balance Due**	Yes	Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**
32.	**Name and Address of Facility Where Services Are Rendered**	Yes	Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

Sample A HCFA-1500 Claim Form
Medicare/Medicaid Crossover

Sample B HCFA-1500 Claim Form
Medicare/Medicaid Crossover

Health & Recovery Services Administration (HRSA)
Speech/Audiology Program
Effective July 1, 2006

Link To Legend For Code Status Indicator

Code Status Indicator	Code	Mod	Maximum Allowable NFS	Maximum Allowable FS	PA?	Comments
	Audiologists and Speech Therapy Pathologists					
R	92506		$81.40	$29.81		
R	92507		$38.52	$17.66		
R	92508		$18.11	$8.94		
R	92551		$10.38	$10.38		
R	92611		$82.32	$82.32		
R	97532		$14.90	$14.90	LE	
R	97533		$16.05	$16.05	LE	
	92630		B.R.	B.R.		
	92633		B.R.	B.R.		
	Audiologists					
R	69210		$29.81	$20.41		
R	92541	26	$13.99	$13.99		
R	92541	TC	$20.18	$20.18		
R	92541		$34.17	$34.17		
R	92542	26	$11.47	$11.47		
R	92542	TC	$23.39	$23.39		
R	92542		$34.85	$34.85		
R	92543	26	$3.67	$3.67		
R	92543	TC	$12.38	$12.38		
R	92543		$16.05	$16.05		
R	92544	26	$8.94	$8.94		
R	92544	TC	$18.80	$18.80		
R	92544		$27.75	$27.75		
R	92545	26	$8.03	$8.03		
R	92545	TC	$16.51	$16.51		
R	92545		$24.54	$24.54		
R	92546	26	$9.86	$9.86		

Code Status Indicator	Code	Mod	Maximum Allowable NFS	Maximum Allowable FS	PA?	Comments
R	92546	TC	$44.03	$44.03		
R	92546		$53.89	$53.89		
R	92547		$2.98	$2.98		
R	92552		$11.01	$11.01		
R	92553		$16.51	$16.51		
R	92555		$9.63	$9.63		
R	92556		$14.45	$14.45		
R	92557		$30.27	$30.27		
R	92567		$13.30	$13.30		
R	92568		$9.63	$9.63		
R	92569		$10.32	$10.32		
R	92579		$18.34	$18.34		
R	92582		$18.34	$18.34		
R	92584		$62.14	$62.14		
R	92585		$63.29	$63.29		
R	92585	26	$16.97	$16.97		
R	92585	TC	$46.32	$46.32		
R	92586		$46.32	$46.32		
R	92587		$37.38	$37.38		
R	92587	26	$4.59	$4.59		
R	92587	TC	$32.79	$32.79		
R	92588		$49.30	$49.30		
R	92588	26	$12.15	$12.15		
R	92588	TC	$36.92	$36.92		
R	92601		$83.69	$83.69		
R	92602		$57.33	$57.33		
R	92603		$51.82	$51.82		
R	92604		$33.02	$33.02		
R	92620		$27.97	$27.97		
R	92621		$7.11	$7.11		
R	92625		$27.52	$27.52		
R	92626		$52.74	$52.74		
R	92627		$13.30	$13.30		

Code Status Indicator	Code	Mod	Maximum Allowable NFS	Maximum Allowable FS	PA?	Comments
	Speech Language Pathologists Only					
R	92526		$51.59	$17.66		
R	92597		$60.08	$30.96		
	92605		Bundled	Bundled		
	92606		Bundled	Bundled		
R	92607		$73.61	$73.61		
R	92608		$13.76	$13.76		
R	92609		$38.06	$38.06		
R	92610		$82.32	$82.32		

Status Indictors

D = Discontinued Code
N = New Code
P = Policy Change
R = Rate Update
# Not Covered in this program

Legend

PA= Written Fax Prior Auth
EPA = Expedited Prior Auth
LE = Limitation Extension
B.R. = By Report
A.C. = Acquisition Cost